**DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS**
**OFFICE OF FACILITIES AND PROGRAM STANDARDS AND LICENSURE**
**Barry Hall, Harrington Road**
**Cranston, Rhode Island 02920**
**462-6049**

# DDD LICENSE RENEWAL APPLICATION
**SUBMIT IN DUPLICATE**

PART I. DATE:_____

LICENSE NUMBER:_____

1. Type of Licensure Renewal: Residential____ Agency____

2. Agency Information
   - A) Name:_____
   - B) Address:_____
   - C) Telephone Number:_____ Fax Number:_____
   - D) Executive Director:_____
   - E) Type of Ownership: Individual_____ Partnership_____ Corporation_____
   - F) Check One: Proprietary:_____ Non-Profit:_____
   - G) List date of agency incorporation:_____
   - H) (**Agency Renewal Only**) Attach a listing of Board of Directors (name, address, title, term of office)

3. Name of Facility:_____
   - A) Address:_____
   - B) Telephone Number:_____ Fax Number:_____
   - C) Type of Facility/Program: Group Home___ Apartment__
     Day Program/Habilitation Center___
     Other_____
   - D) Initial Opening Date:_____
   - E) Residential/Program Manager:_____

4. Physical Plant

A) Name and Address of Owner:_____

B) Type of Building:_____

C) Type of Zoning:_____

D) Type of Construction:_____

E) Number of Stories:_____

F) Number of Rooms:_____

G) Capacity:

1. Residential_____

2. Habilitation Program_____

H) List date and results of most recent fire inspection:

_____

5) Is agency, facility or program licensed, certified or accredited by any other authority?

Yes _____ No _____

A) If yes, by what authority and list types of license, accreditation or certification?

_____

B) If no, has or will application be made to any other authority? Yes_____No_____

If yes, what authority and type of license, accreditation or certification?

_____

6) Has any application for a license, certification or accreditation ever been refused?

Yes _____ No _____

If so, explain:_____

7) Please attach a listing of all the Agency Day Site locations (if applicable):

8) If Agency licensure renewal: Attach a listing of all sites for supported persons who do not live in family homes. Please include the address and the capacity of the site, and the name(s) of the supported person(s) at the site (Note: this listing should **not** include presently licensed 3-person homes or community residences).

PART II:

NARRATIVE

1) Please describe any changes in your program since your last application.

2) FINANCIAL

   A) Describe funding sources and amount funded by each source. (Include any fees charged to clients).

   B) Current budget

   C) List accountant and date of last audit.

Date_____ _____

SIGNATURE OF EXECUTIVE DIRECTOR

*** PLEASE SUBMIT 2 COMPLETE COPIES OF THIS APPLICATION AND ALL SUPPORTING DOCUMENTS TO:**

MICHAEL MCAFEE, ACTING ADMINISTRATOR OF COMMUNITY SERVICES
OFFICE OF FACILITIES AND PROGRAM STANDARDS AND LICENSURE
DEPARTMENT OF MENTAL HEALTH, RETARDATION AND HOSPITALS
BARRY HALL, 14 HARRINGTON ROAD
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